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# Drilling Down in Norm Diffusion: Norm Domestication, "Glocal" Power, and Community-Based Organizations in Global Health

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Norm diffusion scholarship analyzes how states come to agree and adopt new international norms. Yet, formal adoption of a new norm does not in itself guarantee that a government will also implement it domestically, and very little international relations scholarship drills down deep enough to examine whether and how new international norms are subsequently integrated, incorporated, and translated at sub-state level. This article initiates a research agenda on norm "domestication" through the first in-depth study of how international norms in the field of global health are locally incorporated by community-based organizations (CBOs). Drawing upon multi-sited international fieldwork in Uganda, Ukraine, and El Salvador, the paper uncovers three norm domestication strategies used by CBOs of people affected by HIV/AIDS: harnessing political divisions within national governments, circumventing government policy with international help, and mounting legal challenges to government policy. The article argues that these CBO strategies represent "glocal" forms of power capable of forging local–global connections through combined practices of norm allying, norm implementation, and norm intertwining. These subtler processes of norm domestication, the article concludes, ultimately require a reconceptualization of norm diffusion not just as a transnational phenomenon, but as a "multi-local" process during which norms are concurrently localized across diverse geographic locales.

Les recherches sur la diffusion des normes analysent la manière dont les États en viennent à accepter et adopter de nouvelles normes internationales. Pourtant, l'adoption officielle d'une nouvelle norme ne garantit pas en elle-même qu'un gouvernement la mettra également en œuvre au niveau national, et très peu de recherches en relations internationales explorent ce sujet d'une manière suffisamment approfondie pour examiner si et comment de nouvelles normes internationales seront ensuite intégrées, incorporées et traduites au niveau sous-étatique. Cet article amorce un programme de recherche sur la « Domestication » des normes par le biais de la première étude approfondie sur la façon dont les normes internationales dans le domaine de la santé mondiale sont incorporées localement par les organisations communautaires. Cet article s'est appuyé sur un travail de terrain international mené sur plusieurs sites, en Ouganda, en Ukraine et au Salvador, qui a permis de découvrir trois stratégies de domestication des normes employées par des organisations communautaires de personnes affectées par le VIH/SIDA: l'exploitation des divisions politiques au sein des gouvernements nationaux, le contournement de la politique gouvernementale avec l'aide internationale et l'instigation de défis juridiques contre la politique gouvernementale. Cet article soutient que ces stratégies d'organisations communautaires représentent des formes « glocales » de pouvoir capables de forger des relations entre l'international et le local par le biais de pratiques combinées d'alliance des normes, de mise en œuvre des normes et d'entrelacement des normes. Il conclut qu'en définitive, ces processus plus subtiles de domestication des normes exigent une reconceptualisation de la diffusion des normes, non seulement en tant que phénomène transnational, mais aussi en tant que processus « multi-local » durant lequel les normes sont simultanément localisées en divers lieux géographiques.

Los estudiosos de la difusión de normas analizan cómo los Estados llegan a acordar y adoptar nuevas normas internacionales. Sin embargo, la adopción formal de una nueva norma no garantiza por sí misma que un gobierno la aplique también a nivel nacional, y son muy pocos los estudiosos de las relaciones internacionales que profundizan lo suficiente para examinar si las nuevas normas internacionales se integran, incorporan y traducen posteriormente a nivel subestatal, y cómo lo hacen. Este artículo inicia un programa de investigación sobre la "domesticación" de normas mediante el primer estudio en profundidad sobre cómo las organizaciones comunitarias (OC) incorporan localmente las normas internacionales en el ámbito de la salud mundial. Sobre la base de un trabajo de campo internacional en Uganda, Ucrania y El Salvador, el artículo ha encontrado tres estrategias de domesticación de normas utilizadas por las OC de personas afectadas por el VIH/SIDA: aprovechar las divisiones políticas dentro de los gobiernos nacionales, eludir la política gubernamental con ayuda internacional y presentar desafíos legales a la política gubernamental. El artículo sostiene que estas estrategias de las OC representan formas "glocales" de poder capaces de forjar conexiones locales y globales a través de prácticas combinadas de alocución de normas, aplicación de normas y entrelazamiento de normas. Según concluye el artículo, estos procesos más sutiles de domesticación de las normas requieren en última instancia una reconceptualización de la difusión de las normas no solo como un fenómeno transnacional, sino como un proceso "multilocal" durante el cual las normas se localizan simultáneamente en diversos lugares geográficos.

## Introduction

Norms are central to international relations (IR) because they can influence, shape, and constrain state behavior (Stoeva 2010). How new international norms are generated in the international system has therefore been the subject of extensive scholarship, which understands such norms to be the values (or principles) shared by a considerable number of states and international actors (Wiener 2009; Krook and True 2010; Brown 2014). In addition to the initial generation of such new norms in various international fora, however, it is equally important to understand how those new norms subsequently travel and spread to other countries around the world. Norm "diffusion" thus refers to this protracted process bridging the initial generation of new norms at international level and their eventual national adoption by states (Finnemore and Sikkink 1998; Risse and Sikkink 1999; Acharya 2004). To date, IR scholars of such norm diffusion have focused overwhelmingly on the formal adoption of international norms by state representatives (also referred to as "appropriation"), in the belief that formal

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acceptance is then correlated with the subsequent integration of those norms into the national practice of states (Risse and Sikkink 1999; Krook and True 2010; Stoeva 2010; Towns 2012; Brown 2014).

Often, however, the way in which norms "travel" around the world is far messier than this. Formal government adoption of a new norm does not in itself guarantee that it will also be effectively incorporated into the internal or domestic practice of a state. For example, many countries are signatories to the Universal Declaration of Human Rights but continue to display very "poor" records of protecting human rights within their national jurisdictions. Studying what happens *after* the formal appropriation of an international norm is therefore an equally important (if not even more pertinent) aspect of norm diffusion demanding further analysis. This is when a norm encounters the realities of domestic conditions, including the contestation of norms by the very governments that have formally ascribed to a new international norm (Stevenson 2013; Brown 2014). Vernacularization emerges as an area of literature that directly refers to the role of other non-state actors in norm diffusion. Levitt and Merry focus their study of vernacularization on the local uses of global women's rights. For these authors, local non-state organizations, such as non-governmental organizations (NGOs), act as facilitators of the adaption of ideas generated by human rights and feminist movements to fit local contexts (Levitt and Merry 2009; Madsen 2018).

However, very little IR scholarship actually drills down to this level of detail to explore whether and how new international norms subsequently become "domesticated" *within* a country—that is, integrated, incorporated, and translated locally at the sub-state level. Although there is an increasingly comprehensive understanding of norm diffusion between states in intergovernmental and diplomatic fora, the intricate processes of norm domestication unfolding *inside* countries are comparatively understudied, leaving scholars with a much opaquer picture. That imbalance in the scholarly literature must change if we wish to attain a better understanding of how norms ultimately reach the people they are intended for. This article sets out a research agenda focusing specifically on the *domestication* of international norms. It does so via an in-depth analysis of global health norms, which are defined as the principles for action to address health challenges that require cross-border collaboration. These principles are contained in rules, agreements, commitments, and normative guidelines (such as public health policies and service protocols) established or promoted by "states, intergovernmental organisations and non-state actors" (Fidler 2010, 3; Harman 2012; Youde 2012). Within this burgeoning field of global health, the article examines the international response to HIV/AIDS as a particularly powerful exemplar of a governance system extensively regulated by a multiplicity of international (ethical, legal, medical) norms including normative guidance produced by a unique global governance exclusively dedicated to HIV, which includes specialized multilateral institutions such as Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), alongside World Health Organization (WHO) (Elbe 2009; Nguyen 2010; Seckinelgin 2012).

Closer analysis of this international HIV/AIDS response reveals that norm domestication is profoundly shaped by local actors "on the ground." Community-based organizations (CBOs) can be an especially critical—if frequently overlooked—actor advancing norm domestication (Reza-Paul et al. 2008; Campbell and Cornish 2010; Mburu, Iorpenda, and Muwanga 2012). CBOs exert this influence because they have long been relied upon for the local implementation of HIV/AIDS programs around the world (Glynn et al. 2008; Sarkar 2010; Restoy and Teltschik 2014). Detailed analysis of several CBOs of people affected by HIV around the world reveals at least three different norm domestication strategies: harnessing political divisions within national governments, bypassing governments with outside help, and mounting formal legal challenges to government policy. These strategies, we argue, constitute "glocal" types of power capable of forging powerful local–global connections through combined practices of norm allying, norm implementation, and norm intertwining. Uncovering these subtler processes of norm domestication in the field of global health ultimately requires a theoretical reconceptualization of norm diffusion not just as a transnational intergovernmental process, but as a power-laden "multi-local" process during which norms come to be concurrently localized across a diverse array of multiple geographic locales.

## Norm Domestication: Navigating the "Global" and the "Local" in Norm Diffusion

Norm diffusion is the pathway that international norms take on the way toward reaching those they are intended to reach. The study of norm diffusion is "essential to develop a better understanding of the nature and evolution of this key element of international policy making" (Stoeva 2010, 1). Yet, the vast majority of norm diffusion scholarship in IR focuses at the international and intergovernmental level, where norms are initially proposed and then socialized between governments through diplomatic negotiation—eventually leading to state appropriation and formal adoption of an international norm (Risse and Sikkink 1999; Stoeva 2010; Towns 2012). The existing literature does acknowledge that non-state actors, like NGOs and think tanks, can act as "outside" proponents (or external norm entrepreneurs) at the international level (Wiseberg 1992; Lauren 1998; Clark 2001; Tsutsui and Wotipka 2004; Kravtsov 2009; Greenhill 2010). Yet, states are usually given primary analytical weight in the literature because states can legally commit all actors within their jurisdiction to the compliance with new international norms, because states have political responsibility for subsequently incorporating such new norms into their own national practice, and because governments have the power to ensure that norm compliance is enforced within their jurisdiction (Checkel 1998; Cortell and Davis 2000; Acharya 2004; Björkdahl 2005; Domínguez 2010). States are therefore widely seen in the literature as the primary norm "takers" when it comes to norm diffusion.

This analytical focus at the international diplomatic and intergovernmental level, along with its associated state-centrism, is also reflected in the major conceptual approaches for studying norm diffusion processes. Finnemore and Sikkink's influential "life cycle" model, for example, argues that norms can change and evolve as they move from initial emergence, via diffusion, to eventual internalization by states at the end of the cycle—at which point the norm is widely accepted, complied with, and implemented by state structures to the point of being taken for granted and not being any longer a "matter for public debate." By contrast, the alternative "spiral" model of norm diffusion focuses on the impact of norms on the behavior of states at the moment when international norms are socialized among those states, and it presents five phases of such socialization: domestic

repression, state denial, tactical concessions, prescriptive status, and, finally, rule-consistent behavior (Risse and Sikkink 1999; Schmitz 1999). Their significant differences notwithstanding, both prominent norm diffusion models converge in considering the state as the primary entity determining whether and how international norms are diffused in the end.

Far less IR scholarship drills down to the sub-state level to also explore what happens to an international norm *after* a government has formally "appropriated" it or when a government even actively refuses to accept an emerging international norm. Obtaining a clearer picture around this crucial aspect of the norm diffusion puzzle requires far more detailed analysis of how international norms encounter domestic conditions "inside" countries and meet local realities "on the ground" (Acharya 2004; Stevenson 2013; Brown 2014). A few pioneering norm diffusion scholars have begun to explore this critical stage in more detail. In a ground-breaking study, Amitav Acharya finds that the alignment of international norms with national conditions often entails governments having to adapt an international norm that they have appropriated before introducing it into its internal practice (domestication) so that it also conforms to local realities, in a process referred to as norm localization (Acharya 2004). At this point, a number of "local" government and nongovernment actors—such as local elites, NGOs, or other active civil society—can also become highly relevant because they can advocate for an international norm to be either adopted, localized, or contested by the state (Nadelmann 1990; Acharya 2004; Kravtsov 2009). For Acharya, such norm "localization" describes the translation process whereby "foreign ideas" are fitted "into indigenous traditions and practices" (Acharya 2004, 244).

In his work on health systems strengthening in South Africa, Garrett Brown understands such norm localization to be a much more multidirectional process. Brown's account allows for a significant degree of norm modification along the way, especially as the national leadership (still largely circumscribed to state actors at the higher level of political hierarchy) can play a vital role in appropriating or otherwise, contesting, modifying, adapting, or disregarding norms. Existing norm diffusion models, Brown argues, pay insufficient attention to the intersubjective "glocalisation" that occurs in the interface between the global and the local (Brown 2014, 881). Brown ultimately concurs with Acharya that state actors are unlikely to appropriate international norms straightforwardly without the influence of domestic social foundations and practices, in particular, the national leadership (Brown 2014).

The pioneering work of scholars like Acharya, Brown, and others is helping to raise awareness among IR scholars about just how vital local processes are to norm diffusion, and about the fact that we do not yet have a very clear or comprehensive scholarly picture of the processes surrounding the subsequent domestic translation, integration, and incorporation of new norms "within" countries—especially at sub-state level. How do international norms become domesticated at sub-state and local level? And how do those processes relate to the norm diffusion processes unfolding at national and international level? Global health is a fruitful area to explore when searching for answers to these questions, and the AIDS pandemic, in particular, has already marked a vital site for further study and conceptual advancement across the social sciences (Seckinelgin 2005; Clapham 2006; de Waal 2006; Biehl 2007; Forman 2008; Pogge 2008; Marks 2009; Nguyen 2010; Baral et al. 2012). More crucially still, the AIDS pandemic has even engendered a global governance system that, from its very outset, was profoundly shaped by norms—especially human rights norms (Kamradt-Scott 2010; Barnes and Brown 2011; Brown 2014). A broad range of ethical, legal, and medical norms (e.g., around prior informed consent, privacy, disclosure of health status, non-discrimination, the right to health, and human rights-based HIV interventions) have long outlined key principles of the international HIV response and are also extensively detailed in an array of UNAIDS or WHO guidelines (Dogson, Lee, and Drager 2002; Vieira 2007; McInnes et al. 2012). Many of these international norms are now widely promoted and enforced within HIV programs funded by international donors and/or national governments.

However, the task of implementing all those normative programs "on the ground" subsequently falls to a much broader myriad of national and local actors—including government agencies, national and international NGOs, as well as a host of local organizations (Zembe, Towsend, and Mathews 2010; Brown and Labonté 2011). CBOs often play a particularly pertinent role in locally implementing such HIV/AIDS programs. These CBOs, which have so far not been the subject of norm diffusion scholarship, are broadly defined by three main characteristics: CBOs are not-for-profit organizations; they are mostly formed of (and managed by) members of the community or population that they represent, and they principally exist to provide services to and/or represent such community or population (Chechetto-Salles and Geyer 2006). Such CBOs of people affected by HIV/AIDS form a highly significant study site for improving our understanding of how international norms become domesticated. Exactly how do CBOs help domesticate international HIV/AIDS norms "in country"? How do CBOs working at the local level also relate to, and interact with, formal government actors—especially those resisting international HIV/AIDS norms around access to treatments, non-discrimination, human rights, and so forth? What sources of power, moreover, do CBOs mobilize to shape and advance the local domestication of global health norms around HIV/AIDS?

To answer these questions, we carried out three in-depth, multi-sited international case studies of CBOs of people affected by HIV/AIDS. The investigation did not aim to produce a formal comparative case study analysis, but it did seek to review a diverse array of contexts and was therefore driven by three methodological considerations. First, we deliberately selected a spread of CBOs located in three different regions around the world and operating within the context of quite different HIV epidemics, to obtain a wide-ranging and comprehensive picture: (1) lesbian, gay, bisexual and transgender (LGBT) people in Uganda, (2) people who use drugs in Ukraine, and (3) people living with HIV in El Salvador. Second, we focused our analysis on moments in time when respective national governments were *not* acting in accordance with widely accepted international norms around HIV/AIDS, as this allows us to better "test" analytically the strength of the CBO influence over norm domestication. Finally, we selected cases where we could carry out extensive in-country interviews to obtain a better understanding of local processes.

We undertook a total of sixty-three such (mostly semi-structured) in-depth interviews with members and leaders of CBOs, as well as a plethora of other actors and stakeholders relevant to the domestication of global health norms—including NGOs, representatives of intergovernmental agencies, government officials, members of the judiciary, law enforcement agencies, legislative, social, and religious

leaders, media representatives, academics, and other key actors. The ethical imperative to protect participants from the personal, political, and security risks surrounding their often sensitive testimony means that these interviews had to be conducted anonymously, and that their testimonies cannot be directly reproduced here. Yet, the interviews directly inform our wider analysis and are combined with extensive desk research, as well as being further triangulated with epidemiological data sourced from official documents published by governments and international organizations.

The key findings from those three case studies suggest that CBOs have significantly advanced the domestication, and therefore also diffusion, of international HIV/AIDS norms. These findings differ from the nascent scholarship on norm "localization" in at least two key respects. First, unlike the norm localization processes described in the literature (e.g., Acharya in relation to Association of Southeast Asian Nations (ASEAN) and Brown in relation to South Africa), the domestication of these HIV/AIDS norms occurred largely *without* an intermediary stage of translation, during which international norms are adapted to meet local customs and traditions. Rather, these norm domestication processes consisted of a direct and unmediated domestic "appropriation" of international HIV/AIDS norms by local CBOs. CBOs were able to assemble, combine, and give political force to constituencies within the country that often already shared those norms, and worked locally toward their actualization "on the ground." This finding requires an analytical distinction between processes of norm "localization," whereby norms are adapted and renegotiated to fit local conditions, and norm "domestication," whereby international norms are locally appropriated and implemented largely without such extensive adaptation.

Second, these norm domestication processes were *not* principally vested in the state or "in the nation and the leadership role it exerts" (Brown 2014, 877). Rather, they mostly unfolded at sub-state level and were largely driven by the activities of highly localized CBOs. In all three cases, in fact, such international HIV/AIDS norms became further domesticated in a wider political context of rejection by national leadership. This explicit opposition to the implementation of such international norms responds to a variety of reasons explored below, but which stem from the fact that populations at higher risk of HIV (LGBT people or people who use drugs, for example) are often discriminated against and, on occasion, persecuted by their own governments. Those unfavorable national political environments notwithstanding, CBOs were still able to advance the domestication of international HIV/AIDS norms through three different strategies: harnessing political divisions within national governments, circumventing government policy with international help, and mounting legal challenges to government policy. Moving forward, this finding demands far greater analytical attention to the role of non-state actors in norm diffusion and domestication processes.

## Channeling Divisions within the State: LGBT Organizations in Uganda

The first way in which CBOs have advanced the domestication of international HIV/AIDS norms is by building powerful norm alliances with other like-minded local actors. This can be seen particularly clearly in the case of Uganda, where twenty-three semi-structured interviews were carried out with government officials and people in leadership positions in CBOs and NGOs between 2010 and 2017. In Uganda, the LGBT population has been coming out against homophobia and transphobia over the past decade, albeit in the context of a deeply conservative society in which (in 2010) around 96 percent of people considered homosexuality to be morally unacceptable (The Pew Forum 2010). With social and political repression of LGBT people already at its height, a bill to further persecute homosexuality was tabled in parliament in 2009 and was subsequently used by politicians to threaten this population (as well as wider groups and organizations supporting LGBT rights). Even the country's president warned that "I've told the CID [Criminal Investigations Department] to look for homosexuals, lock them up and charge them."[1]

The Anti-homosexuality Bill represented a key landmark in Uganda's rejection of the rights of LGBT people, and its passing was tainted with further allegations of widespread human rights violations (like arbitrary arrest and police harassment) committed against the LGBT population (Amnesty International 2008a,b; Tamale 2009). For example, the bill contained measures to criminalize the promotion of homosexuality and even to compel HIV testing for LGBT people in certain circumstances. It also proposed the death penalty for "aggravated homosexuality."[2]

During this same period of 2013–2014, the LGBT population in Uganda (especially men who have sex with men, as well as transgender people) was also confronting one of the worst HIV epidemics in the world. The percentage of adults aged between 15 and 49 living with HIV had risen to 7.3 percent in 2011 (Ministry of Health of Uganda 2011). Yet, the Ugandan national response to HIV/AIDS largely mirrored the wider political and judicial persecution of LGBT people. The national response focused mostly on biomedical interventions aimed at the wider population in the context of a generalized HIV epidemic, to the detriment of minority populations at higher risk of HIV. The Ugandan authorities systematically avoided providing support to LGBT people affected by HIV; they did not report on the percentage of men who have sex with men (MSM) or transgender people among people living with HIV (SGJN and Men Engage 2013). In 2012, a study estimated that HIV prevalence among MSM in Uganda was 13.7 percent (Hladik et al. 2012). However, there was no official data on any aspect of the impact of HIV on MSM or transgender people. The disregard shown by the national response to HIV among MSM and transgender people, along with widespread social perception that HIV was transmitted by homosexuals, helped to undermine the access of LGBT people to HIV prevention and treatment programs (Long Brown, Cooper 2003; Tamale 2007).

In conjunction with the attempted criminalization of homosexuality, this approach taken by the Ugandan authorities ran counter to widely accepted international human rights-based norms around HIV. Those require the provision of targeted services to key populations (including LGBT people). International institutions were unequivocal in considering legislation that criminalized homosexuality as a factor that both causes and boosts the rate of HIV infection among MSM. For example, the International Commission on HIV and the Law stated, "there is growing international consensus that the decriminalisation of

[1] The New Vision, "Arrest Homos, Says Museveni," September 28, 1999.

[2] "Aggravated homosexuality" is defined by the bill as "(a) person against whom the offence is committed is below the age of 18 years; (b) offender is a person living with HIV; (c) offender is a parent or guardian of the person against whom the offence is committed; (d) offender is a person in authority over the person against whom the offence is committed; (e) victim of the offence is a person with disability; (f) offender is a serial offender, or (g) offender applies, administers, or causes to be used by any man or woman any drug, matter or thing with intent to stupefy, overpower him or her so as to thereby enable any person to have unlawful carnal connection with any person of the same sex."

homosexuality is an essential component of a comprehensive public health response to the elevated risk of HIV acquisition and transmission among men who have sex with men" (UNDP 2012, 48). Scientific evidence further showed that, across a range of epidemic settings, universal access to HIV services for MSM together with anti-discrimination efforts can significantly reduce infections among both those men and the wider community (Beyrer et al. 2011; UNAIDS 2011).

Yet, despite this mounting social and political repression of LGBT people in 2013–2014, CBOs of LBGT people were still able to contribute to the domestic HIV/AIDS response in Uganda even as they struggled to advocate to stop their own persecution. For example, in 2012, the CBO Icebreakers opened a clinic in Kampala to provide HIV and sexually transmitted disease services to LGBT people.[3] This new outreach clinic eventually even entered a partnership with the Ugandan health authorities. In contrast to the country's political leadership, the latter began to signal greater openness to the provision of HIV and other health services to LGBT people. This could be done through "intermediary" services such as the Most At-Risk Populations Initiative (MARPI) program, which complemented the work of the Ministry of Health at Mulago (the largest public referrals hospital in Kampala). This partnership between Icebreakers and MARPI would include the provision of doctors from the public health care service to the Icebreakers clinic, as well as joint outreach campaigns in provinces all over Uganda (Bourne, Fearon, and Nutland 2016). The MARPI leadership deemed this partnership necessary to hit the service reach targets (to men who have sex with men and transgender people) set out by the international funders of the initiative.

These activities by Icebreakers in Uganda reveal how it can still be possible for CBOs to advance the domestication of global health norms supporting the provision of health services to LGBT people, even where this contravenes national laws and state policies. In this case, the CBO was able to do so, in part, because of the political differences that existed within, as well as across, the Ugandan national government. "[A]lthough the influence of global policy can play an important guiding role," Brown argues in relation to the case of South Africa, "health norms are never transcribed straightforwardly into national systems and a central element of successful health governance remains vested in the nation and the leadership role it exerts" (Brown 2014, 878). Yet, in the Ugandan case, the situation was exactly the opposite way around. It was the state's representatives in the Ministry of Health that acted very differently in relation to the LGBT population when compared to other state representatives located within the executive and the judiciary. Icebreakers would thus find itself in the paradoxical situation of actually contributing to the national HIV response with recognition from the Ugandan Ministry of Health, while being simultaneously persecuted by most other state structures—including the Presidency itself, as well as other powerful state institutions such as the Ministries of Ethics and Integrity, Security, Information, and law enforcement institutions (Amnesty International 2008a,b).

The case of Icebreakers in Uganda shows how a CBO managed to contribute to the local domestication of international HIV/AIDS norms through a strategy of channeling political differences *within* the state to form localized, but nevertheless powerful, norm alliances around HIV/AIDS with the help of like-minded actors within the state. The impact of such CBO activities is not insignificant. In the case of Icebreakers alone, their partnership with MARPI benefited over 1,800 LGBT people between 2013 and 2015 through joint mobile testing and counseling and referrals for HIV and sexually trasmitted infection (STI) treatment in public health services in fourteen towns.[4] There is thus the complex, and at times even contradictory, relationship between CBOs and the state, pointing to the need to pay far more analytical attention to the role that non-state actors can also play in norm domestication.

## Bypassing Governments with Outside Assistance: People Who Use Drugs in Ukraine

Implementing norms outside the official purview of the state is a second way in which CBOs can locally advance the domestication of international norms. That can be seen particularly clearly in the case of Ukraine. In 2010, the country was confronting a severe HIV crisis among people who use drugs as the HIV prevalence rate among the drug-injecting population rose to 22.9 percent. This marked one of the highest rates in the world at the time[5] and reflected a wider regional trend in Eastern and Central Europe (UNAIDS 2011). At the same time, Ukraine also maintained strict drug policy legislation to combat illicit drug circulation. Criminal responsibility for the possession of even small amounts of illegal drugs was conferred to people through a variety of legislation—including Articles 309 and 303 of the Criminal Code of Ukraine, Article 185 of the Administrative Code of Ukraine, the Law of Ukraine "On Response to Illicit Drug Circulation. . .," and the Law "On the Militia." Such criminalization of drug possession deterred people who use drugs from approaching any health or social services, because they feared being reported to, and being detained by, the police (Maksymenko 2010). Pre-trial detention, during which pre-trial detainees in Ukraine could often await trial for over a year, was a further barrier for drug users seeking treatment (Wolfe 2007).

As in the Ugandan case above, this situation was again largely at odds with broadly accepted international norms around HIV/AIDS. Internationally established practices to reduce HIV transmission among people who use drugs are based on harm reduction interventions (WHO 2004). Normatively, these interventions require the consideration of drug users not as criminals or as threats to security, but as patients in need of support (Wodak and Cooney 2006). The common internationally recommended harm reduction package for such patients comprises two main interventions. First, needle and syringe exchange programs provide sterile injecting equipment to people who use drugs in exchange for used equipment, to reduce the risk of transmission between people who share equipment. Second, drug substitution maintenance treatment (SMT), normally through the controlled administration of methadone or other synthetic opioids (DPA 2006), is also offered to reduce the risks associated with the uncontrolled use of heroin and other illegal opioids (Mattick et al. 2003; Spire, Lucas, and Carrieri 2007).

Yet, the criminal persecution of people who use drugs by the authorities made the implementation of those internationally recommended measures very difficult in Ukraine. Nor was such state persecution even confined to those who use drugs; it frequently extended much more widely to

[3] ILGA (2019).

[4] Frontline AIDS, "Men's Sexual Rights and Health Programme (SHARP)."https://frontlineaids.org/what-weve-learned/sharp/, accessed on February 4, 2021.

[5] USAID, Ukraine: Health, https://www.usaid.gov/ukraine/global-health, accessed on February 14, 2021.

also affect organizations and practitioners providing HIV and harm reduction services. This persecution peaked in May 2010, when Dr Illya Podolyan (a renowned harm reduction physician) was detained by the Odessa police and then charged with allegedly committing over forty-two offences related to drugs trafficking (Hurley 2010). He was remanded in prison for several months but was finally acquitted of all counts in September 2010. In January 2011, the Ministry of Interior's drug enforcement department also ordered comprehensive inspections of harm reduction programs across the country. Hundreds of patients receiving SMT, along with the NGOs and CBOs that provided such therapy, faced harassment and abuse from state authorities. Documents were reportedly confiscated from charity organizations; in some cities programs for drug users stopped for several days.[6]

Club NGO ENEY (*Drug Users Anonymous*) was one of the most pertinent such Ukrainian CBOs of people who use drugs. To study its activities in more detail, we carried out further semi-structured interviews with four activists from ENEY in leadership positions in the 2010s and 2020s, as well as another fifteen interviews with other NGOs and representatives from the Ministry of Health and the Ministry of Interior of Ukraine. ENEY focused on harm reduction programs for drug users, as well as the provision of HIV services. It frequently operated at considerable risk because the mere provision of harm reduction services by CBO members could place such harm reduction practitioners at the very edge of legality (Hurley 2010), as state authorities could potentially construe them as nurturing an illegal activity. Yet, the fact that it also managed to continue its activity within this hostile political climate meant that CBOs of drug users in Ukraine like Club NGO ENEY could effectively generate their own domestic practice around harm reduction norms "on the ground"—and to do so largely outside of the official purview of the state. This marks a significant contrast to the Ugandan case above, in which CBOs worked closely with, and even with the support of, the Ministry of Health. In Ukraine, by contrast, official state public health organizations played much less of a role in the provision of such services. Yet, sufficient operational space remained for a CBO to shape the local domestication of international HIV norms without the direct involvement of the government, and to do so largely through a strategy of "bypassing" the government with outside help, notably from the Global Fund.[7]

Ironically, this state persecution of people who use drugs (and of the organizations providing HIV and harm reduction services to this population) also contrasted sharply with the officially stated policies of the Ukrainian health authorities. Like almost all other countries in the world, the government of Ukraine reports periodically on its progress fighting HIV through a monitoring system called United Nations General Assembly Special Session (UNGASS) reporting. In its 2010 UNGASS report, the Ukrainian government claimed that "substitution maintenance therapy using methadone and buprenorphine [opioid substitution therapy (OST)] was received by as many as 5,078 patients at 102 health care facilities in 26 regions of Ukraine. Over two years, the number of drug dependant people who gained access to OST programmes increased nine times, making OST scale up one of the most successful achievements in the national response to HIV/AIDS" (Ministry of Health of Ukraine 2010). Those official claims were odd because, as Nieburg and Carty stressed in 2012, OST had never been part of the narcological services provided by the Ukrainian public healthcare service (Nieburg and Carty 2012). What is more, Ukrainian authorities themselves confirmed that the healthcare service did not provide any such direct harm reduction service to injecting drug users (Ministry of Health of Ukraine 2010).

The national provision of harm reduction programs in Ukraine, for which the Ukrainian government implicitly claimed international "credit," was in reality being implemented by ENEY, other CBOs of drug users, and NGOs. Again, the magnitude and impact of these CBO efforts were considerable. Indeed, between 2013 and 2017, the overwhelming majority of substitution therapy services benefiting over 8,000 people who use drugs in Ukraine were run directly by civil society organizations, totaling over 91 percent of the total Global Fund funding by 2017.[8] All of this, moreover, was happening without any major part being played by the Ukrainian Ministry of Health and other state structures. It was done either through the efforts of CBOs and NGOs, or with assistance from external actors like international NGOs and funding from international donors such as the Global Fund, which has funded HIV and TB programs with people who use drugs run by Ukrainian NGOS and CBOs without interruption since 2004. This support from the Global Fund is consistent with the Fund's defense of the effectiveness of harm reduction programs across the word, as opposed to punishing policies against people who use drugs.[9]

## Legal Challenges to Government Policy: People Living with HIV in El Salvador

A third example in which CBOs can advance the domestication of international HIV/AIDS norms is through protracted legal mobilization. This strategy was particularly effective in El Salvador, which we studied by undertaking twenty-one interviews with HIV activists and trade union representatives in positions of leadership during the 1990s and early 2010, as well as high-ranked government officials during that period. In the 1990s, many people living with HIV in El Salvador were already dying of AIDS-related diseases. The first antiretroviral treatment had recently become available and was proving effective, but its financial costs were so high that many governments refused to provide it to their citizens. During this period, the role of CBOs of people living with HIV was therefore largely circumscribed to providing peer-to-peer support for "victims" of AIDS, and to helping people living with HIV tell their stories as a way of raising awareness of the risks of HIV (Nguyen 2010).

This picture would slowly begin to change in the late 1990s, however, when a CBO of people living with HIV called Atlacatl Vivo Positivo (Atlacatl) began to demand that the state provide free access to antiretroviral (ARV) treatment for people living with HIV. Most of Atlacatl's original members died of AIDS-related diseases before ARVs became more widely accessible. Nevertheless, Atlacatl would grow to become one of El Salvador's most prominent civil society organizations focusing on HIV prevention and advocacy. The origins of the Atlacatl campaign in El Salvador date back to

[6] IHAA, Ukraine campaign Action, January 2011. www.whatspreventingprevention.org, accessed on February 29, 2011.

[7] (UNAIDS 2016).

[8] AIDSPAN, Ukraine starts transition away from Global Fund support without a detailed transition plan, OIG says, http://www.aidspan.org/gfo_article/ukraine-starts-transition-away-global-fund-support-without-detailed-transition-plan-oig, accessed on December 2, 2020.

[9] Global Fund, grants, https://www.theglobalfund.org/en/portfolio/country/list/?loc=UKR&k=c0959d2a-326e-472a-a375-b8e70640560a#page-2, accessed on January 14, 2021.

the mid-1990s, when doctors helping patients with HIV realized that the HIV epidemic was spreading rapidly. Societal perceptions around AIDS remained extremely hostile at the time. AIDS was still widely referred to as the "Pink Plague," and the military and police often harassed sexual minorities, who were perceived as carrying the virus. A few people living with HIV nevertheless managed to launch a campaign that would resonate with the public and which managed to solicit thousands of letters of support (Aguilar et al. 2018). Emboldened by this campaign, the founder of Atlacatl—Odir Miranda (Miranda)—along with other activists mounted a formal legal challenge to the government policy of not providing free treatment.

The activists first took their demand for the free state provision of ARVs to the national judicial system, as they filed legal cases against the Salvadoran Social Security Institute—the *Instituto del Seguro Social de El Salvador* (ISSS)—before the Supreme Court in 1999. Representatives of the conservative Arena government, in power between 1989 (not long after the diagnosis of the first case of AIDS in 1984) and 2010, questioned the legitimacy of a small group to represent the larger population of people living with HIV. In 2000, the Ministry of Health further declared it impossible to provide treatment for people living with HIV, because this would lead the ISSS to bankruptcy (Aguilar et al. 2018). Yet, international norms around the free provision of such treatment were rapidly evolving, especially once a growing number of countries began to make such life-saving treatments available to their population. A crucial regional precedent had also been recently set in Central America when, in 1997, the Supreme Court of Costa Rica ordered the country's National Health Service to provide ARVs to patients because economic interest cannot be prioritized over the right to health. Already it was becoming clear to some government representatives in El Salvador that the financial argument was going to be difficult to sustain considering this Costa Rican precedent. The more time that passed, the more at odds the position of El Salvador's government was with wider international norms moving to the provision of such treatment (Castillo 2011).

On January 24, 2000, and with the ISSS still refusing to provide ARVs, a larger group of twenty-seven people living with HIV (including Miranda and other members of Atlacatl) then escalated its legal challenge into the broader international arena. They presented a formal petition to the regional Inter-American Commission of Human Rights (IACHR). The plaintiffs accused the state of violating the rights to life, to humane treatment, to equal protection of the law, to judicial protection, and to economic, social, and cultural rights—as stated by the American Convention on Human Rights and other international human rights treaties signed and ratified by the Republic of El Salvador.[10] Now the legal case began to take on a whole new dimension, because it was the whole El Salvadoran government being taken to court (not just the social security institute), and because this time the legal exposure was also before an international human rights body, rather than confined to the national justice system.

Ultimately, the government's legal defense failed to convince the IACHR Commissioners and, following their deliberations, the Commission concluded that the state had indeed violated several provisions of the American Convention on Human Rights—specifically Article 2 (adoption of legal provisions to guarantee the rights enshrined in the convention), Article 25 (right to effective judicial protection) as regards to all petitioners, and Article 24 (right to equal protection of the law) in the case of Miranda (IACHR 2009). Soon after, the Commission began dictating precautionary measures demanding that the government provide ARVs to all the petitioners. In response, the government communicated to the Commission that it would initiate a dialogue process with the plaintiffs and Atlacatl by November 2000 aimed at reaching a settlement. The first limited distribution of ARVs through the national health care system now also commenced. As of 2002, however, it only reached around 10 percent of people living with HIV (UNDP 2014).

With the added benefit of hindsight, the outcome of this legal process would also mark the beginning of a much wider turning point that eventually culminated in a dramatic reversal by the government of El Salvador on the entire issue of providing treatment. In the space of a few years, President Francisco Flores's position evolved dramatically. Now it was the presidency establishing national HIV policies and providing instructions directly to the health authorities, which had overseen these policies prior to the commencement of the judicial cases. In 2009, the Head of the National HIV Programme announced the extension of the free provision of ARVs to the rest of the public health service, and the establishment of an ongoing platform of dialogue with Atlacatl and other CBOs caring and supporting people living with HIV (Aguilar et al. 2018). That decision finally placed El Salvador in line with the international norm of free provision of ARVs, which had established itself by the mid-2000s, and was widely upheld by other governments around the world (Reich and Priya 2005).

The case of El Salvador is particularly significant, then, because it marks an instance where a CBO ultimately advanced the domestication of international norms around HIV/AIDS neither with the help of elements within the government nor by bypassing the government with help from the outside. Although the influence of the IACHR was crucial in this domestication, this took place at Atlacatl's own initiative to seize the Commission's involvement. Thus, a CBO was ultimately able to trigger a major reversal in the government's stance on providing universal and free access to ARV treatment through a strategy of protracted legal mobilization. As a result, over 11,500 people living with HIV were receiving free life-saving treatment in El Salvador by 2017.[11] Yet, the CBO's power, in this case, did not come from the force of the law alone; it also derived from the way in which it was able to effectively connect and intertwine multiple norm diffusion processes. By mounting a formal legal challenge, Atlacatl managed to create a powerful link between two international norm diffusion processes: global health norms around the provision of ARVs to people living with HIV/AIDS on the one hand, and wider international human rights norms on the other hand. This powerful norm entanglement would help Atlacatl influence representatives at the highest level of the state hierarchy, even when for a long period of time they had been unable to do so among the health authorities. This process of judicial review would eventually transform El Salvador from a country that for many years denied access to HIV treatments into a regional champion in the free provision of antiretroviral drugs for all people living with HIV (Kavanagh et al. 2015). Norm intertwining is thus a final source of power that CBOs have used to influence norm domestication in global health.

[10] Articles 4, 5, 24, 25, and 26.

[11] UNAIDS, Country Factsheet: EL Salvador. http://www.unaids.org/en/regionscountries/countries/elsalvador, accessed on March 2, 2021.

## Conclusion

The norm domestication processes analyzed here in the field of global health have a number of wider ramifications for the study of norm diffusion moving forward. First, they suggest that the global travel of norms can only be understood through more in-depth research focusing on the detailed norm diffusion processes also unfolding at sub-state level. It cannot be assumed that the domestic incorporation of norms is directly correlated to whether or not a government formally appropriates an international norm. Governments may pay lip service to norms in international fora, without undertaking concerted efforts to subsequently implement such norms domestically. Conversely, governments may reject international norms, and yet non-state actors may still be able to actively promote and advance such norms domestically. In all three of the cases described here, in fact, the national governments were *not* acting in accordance with international HIV/AIDS norms. Yet, the domestication of such norms could still be significantly advanced locally by CBOs. These cases suggest that norm domestication is an equally important process needing to be studied in its own right alongside norm diffusion at national and international levels. Yet, it must also be considered as a phenomenon that is distinct from norm "localization," whereby norms become significantly adapted to meet local conditions. In most cases, researching such processes of norm domestication will only be possible through extensive and detailed local fieldwork; however, there is no alternative to such research if we wish to understand how norms eventually reach the people they are intended to reach.

Second, this shift toward a research agenda on norm domestication also requires expanding the array of heterogeneous actors studied. Norm diffusion scholarship generally tends to consider states to be the foremost "norm taker" in the international system, whose behavior ultimately determines the fate of an international norm within its jurisdiction. Yet, the further one drills down to explore what also happens *after* a government has agreed to a new norm (or indeed rejects an emerging norm), the more significant non- and sub-state actors tend to become. States continue to remain key actors, but they cannot be regarded as the only actors determining the extent and degree of norm domestication. Norms are ultimately not just juridical phenomena but must also exist in their exercise (Speed 2008). Especially in the case of a highly stigmatized illness like HIV/AIDS, local CBOs can exercise a much more "intimate" form of governance that reaches people and spaces which the government itself often cannot. CBOs have thus emerged as a highly significant, if also understudied, actor in the domestication of international HIV/AIDS norms than can be powerful norm takers in their own right. If we wish to take seriously the need to study norm domestication as a vital component of norm diffusion, then we must moderate the overwhelming emphasis on the state as the central and indispensable actor in the diffusion of international norms (Nadelmann 1990; Cortell and Davis 2000; Stoeva 2010).

Third, the study of norm domestication also demands greater analytical sensitivity to the different types of power that are involved in norm diffusion. Working exclusively with the conventional disciplinary matrices of "power" in IR would make it seem highly implausible—even impossible—that small, local, and community-based organizations could compete with the formidable power of states with their extensive resources, bureaucratic structures, and executive agencies. Approached from the perspective of more conventional accounts of power emphasizing coercive force and material capabilities, CBOs would appear to merely form the "smallest" and "weakest" link in the long chain of HIV/AIDS governance—located near the "bottom" of a very long pipe of "top-down" norm diffusion. In the case of HIV/AIDS, however, CBOs have been shown to significantly influence, shape, and even advance the domestication of international norms—and in a context when the much more "powerful" state was *not* acting in accordance with broader global health norms around HIV/AIDS. It is therefore not so much the case that CBOs are not powerful; rather, they need to be seen as possessing a different kind of power. As the above case studies have all revealed in different ways, CBOs have the capability to forge powerful local–global connections through a combination of forming localized norm alliances with like-minded actors, implementing programs on the ground outside of the purview of the state, and intertwining multiple international norms in a local context. We call this composite ability of CBOs to forge such local–global connections through multiple practices of norm allying, norm implementation, and norm intertwining "glocal" power.

Fourth, these case studies also point to the need for scholars to take global health much more seriously as a powerful site of norm diffusion and domestication. With notable exceptions (Mann and Tarantola 1996; Youde 2012; Davies, Kamradt-Scott, and Rushton 2015; and others), global health remains comparatively understudied in relation to much more prominent areas of norm diffusion scholarship—like human rights, democratic values, gender norms, etc. Yet, the global AIDS pandemic has also witnessed the emergence of a noticeably protracted and politically intense international "viral normativity"—whereby receiving treatment is seen to be a human right, while human rights also extensively govern how such treatment is administered. Medical discourses have a particularly formidable discursive potential to "depoliticize" normative differences by transforming them into matters of medical/technical expertise, making them a particularly powerful site of international norm diffusion and domestication. In the case of the three CBOs analyzed here, we have seen how the efforts of national authorities to ostracize particular communities—whether it be LGBT populations in Uganda or people who use drugs in Ukraine—were ultimately met with a powerful medical "counter-discourse" that these people may be first and foremost in need of prevention services or medical treatment. This has created space not just for norm diffusion in the context of caring for people affected with HIV/AIDS, but even in contexts where national governments have overtly pursued policies hostile to groups affected by HIV/AIDS. As counterintuitive as it may seem, the diffusion of new international norms around the world has, in the end, also been made possible by the new ways of acting and being demanded by the spread of a lethal virus.

Finally, the case studies presented here also point toward the need for a deeper theoretical reconceptualization of the process of norm diffusion itself. Exploring and analyzing norm domestication is not merely a case of "filling in" an additional and missing "piece" of the proverbial puzzle; it ultimately also changes the way in which we need to think about the overall process of norm diffusion itself. Norm diffusion must, in the end, also be thought of as a "multi-local" process during which norms become concurrently localized in many different places around the world, demanding further research about the agency of local actors such as CBOs in those processes of norm diffusion, and about the extent to which those local actors also build translocal processes to help each other influence the diffusion of norms. Just like the global AIDS "pandemic" is ultimately an

epiphenomenon made up of the many (millions) of localized infections of people living with HIV around the world, so too the diffusion of an international norm is ultimately a "multi-local" process consisting of a series of many different norm localizations concurrently unfolding across a multiplicity of diverse geographic locals around the world.

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